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SCALING-UP HIV/AIDS FINANCING AND THE ROLE OF MACROECONOMIC POLICIES IN KENYA

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Policy Advisor, UNDP/BDP Caribbean SURF

Prepared for the Global Conference on Gearing Macroeconomic
Policies to Reverse the HIV/AIDS Epidemic,
Brasilia, 20-21 November 2006

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CONFERENCE PAPER

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ABSTRACT

Kenya represents an unusual case study of a country in which HIV/AIDS financing has been on the rise while total ODA and public spending on health have been falling. Governments in low-income countries have often implemented restrictive macroeconomic policies when they are afraid of the inflationary impact of increased ODA. In contrast, the Government of Kenya has resorted to such policies even when ODA has been markedly declining. Whatever aid inflows Kenya has received, they have been neither fully spent nor fully absorbed. One third of ODA has been used to retire domestic debt and another third has been added to reserves. Moreover, the Government tried to achieve an unusually low inflation rate of 3.5 per cent. It also succeeded in cutting its fiscal deficit in half during the dramatic increase in external HIV/AIDS financing. So there has been little danger of a rise in inflation due to expansionary fiscal policies. Related to this, there has also been little danger of appreciation of the exchange rate—namely, a ‘Dutch Disease’ effect that could have undermined the international competitiveness of Kenyan exports. Thanks to a scaling-up of HIV/AIDS financing, Kenya has been able to achieve a significant reduction in the infection rate of the disease although much of the additional financing was directed through non-governmental channels. Arguably, Kenya could have achieved much more had total public health expenditure also been increased and had the Government implemented more expansionary fiscal and monetary policies in support of an aggressive campaign against the epidemic.

* Thanks go to Terry McKinley, Acting Director of the International Poverty Centre (IPC), for providing extensive comments on this paper, which significantly improved its contents. I also thank Ben Fine, professor at the School of Oriental and African Studies, University of London and Eduardo Zepeda, senior researcher at IPC, for serving as the external and internal peer reviewers respectively. They gave many valuable comments and suggestions.

FOREWORD

This Conference Paper on “Monetary Policies for an MDG-Related Scaling up of ODA to Combat HIV/AIDS” was commissioned for the Global Conference on “Gearing Macroeconomic Policies to Reverse the HIV/AIDS Financing”, which was held in Brasilia, 20-21 November 2006. It is the last in a four-part series that contributes to the ongoing debate on macroeconomic policies in low-income countries that restrict the scaling up of financial resources for an expanded HIV/AIDS response.

The conference was jointly sponsored by the HIV/AIDS Group of the United Nations Development Programme, New York and the International Poverty Centre, Brasilia. It brought together representatives from government and civil society, the IMF, HIV/AIDS specialists and economists in a lively and productive dialogue on the policy and practical governance requirements for macroeconomic stability in HIV-affected countries.

The first three Conference Papers, on fiscal policies, monetary policies and exchange-rate policies, have already been published by IPC. We hope that these Conference Papers will make a valuable contribution to the ongoing dialogue and debate on this critical issue, and help motivate further studies at the country level.

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1 INTRODUCTION

Since the first case of HIV/AIDS, it is estimated that close to 25 million people have died and over 40 million people are currently infected. In Kenya, 1.5 million people have died and about 1.3 million people are estimated to be living with HIV/AIDS. About two-thirds are women, particularly those aged 15-24 years. There are an estimated one million orphans and over 100,000 children living with the disease (UNAIDS/WHO, 2006). By 2004, there were about 90,000 new adult infections. This was tantamount to about 250 new infections occurring every day. In 2005, it was estimated that about 150,000 patients die every year due to HIV/AIDS related illnesses (KNASP, 2005). In response, the Government of Kenya established the National AIDS Control Council (NACC) in 1999, and prepared the Kenya National Aids Strategic Plan (KNASP) for 2005-2010.

Kenya presents an interesting case since *total* Overseas Development Assistance (ODA) flows have considerably declined throughout the last decade and a half, with only a slight recovery from 2000 onwards. Despite the decline in overall aid, the country is one of the top ten recipients of health-related *aid* in the world and one of the top ten recipients of HIV/AIDS-related *aid* in sub-Saharan Africa (SSA). At the same time, *public* expenditure on health has been declining, while spending on health by NGOs has been rising. But we also see surges in HIV/AIDS-related spending from public, NGO and donor sources. HIV/AIDS spending as a share of overall aid increased markedly from 5.5 per cent in 2000/2001 to 37.8 per cent in 2004/05, averaging 19.4 per cent for the whole period. Note that ODA flows also recovered from US\$ 512 million in 2000 to US\$ 634 million in 2004. The increase in aid has been directed to HIV/AIDS control, mainly to help import antiretroviral drugs, supply condoms and support behavioral changes.

On various occasions, the donor community has pledged to double aid to control the epidemic. While this promise is yet to be fully realised, the macroeconomic implications of scaling-up spending are fiercely debated. The IMF publication Gupta *et al.* 2006 (p. 10) noted the spending needs for alleviating the HIV/AIDS epidemic and the challenges as follows:

“External grants have been the dominant source of funding for HIV/AIDS-related expenditures in low- and middle-income countries. In several countries, financing needs for HIV/AIDS programs exceed total public health expenditure, and they could rise to up to 10 percent of GDP for some low-income countries. Thus, HIV/AIDS programs can present challenges similar to those associated with the type of significant scaling up of aid.”

The debate focuses on whether increased external assistance causes macroeconomic instability or not. The standard argument is that scaling-up aid will inevitably cause inflationary pressures and appreciation of the exchange rate, which will in turn impact negatively on competitiveness.¹ A major question of this paper is: did the scaling-up of aid to finance HIV/AIDS control in Kenya cause macroeconomic instability? The answer is ‘no’ to the extent that: 1) the resources have not been large enough to upset macroeconomic conditions—HIV/AIDS funding increased, but even at a higher level makes up only 1.5 per cent of GDP; 2) aid has not been spent and has only been partially absorbed—about one-third of the aid was

added to reserves and the same proportion was used to reduce indebtedness; 3) public spending on HIV/AIDS has not increased overall health expenditure since the resources have been reallocated from other health activities; and 4) the bulk of the HIV/AIDS spending has been for importing essential drugs and condoms, avoiding thereby a monetary impact on the domestic economy.

Kenya's macroeconomic policy focused on meeting the low inflation target of 3.5 per cent agreed in the Poverty Reduction and Growth Facility (PRGF). At the same time, continuation of the conservative fiscal policy led to the reduction of the fiscal deficit from -1.7 per cent of GDP to only -0.8 per cent, comparing the periods before and after scaling-up HIV/AIDS-related spending. Including grants, the *surplus* in the fiscal balance was equivalent to 0.4 per cent of GDP during the period when spending on HIV/AIDS was scaled up. There was clearly fiscal space to increase spending on HIV/AIDS without impacting negatively on the macroeconomy. The inflation target is unnecessarily low, especially given the emerging consensus that a rate of 5-10 per cent need not be harmful to growth.

Following increased spending on HIV/AIDS control, Kenya was able to achieve a considerable reduction in the HIV prevalence rate from 14 per cent in 2001 to 5.9 per cent in 2005. To further tackle the epidemic, policy makers need to fully absorb and spend external resources. There is room for more expansionary fiscal and monetary policies to reverse the decline in health expenditure, particularly in light of the linkages between HIV/AIDS and other diseases such as tuberculosis and malaria.

Kenya is not covered by the HIPC Initiative, mainly because its debt level is considered sustainable. However, debt relief would allow Kenya to channel badly needed resources to HIV/AIDS control. So, one of the recommendations of this Conference Paper is to include Kenya as part of the HIPC Initiative in order to provide it with more fiscal space to channel resources to combating HIV/AIDS.

This Conference Paper is organized as follows. The next section charts the history of aid flows to Kenya, illustrating changes in donor interest since the 1990s, when Kenya fell out with the International Financial Institutions (IFIs). Section 3 identifies the size and composition of HIV/AIDS-related expenditure, by source and executing agency. Section 4 examines the impact of scaling-up spending on controlling the disease. Section 5 investigates the effect of scaling-up HIV/AIDS spending on key macroeconomic variables. Concluding remarks are in Section 6.

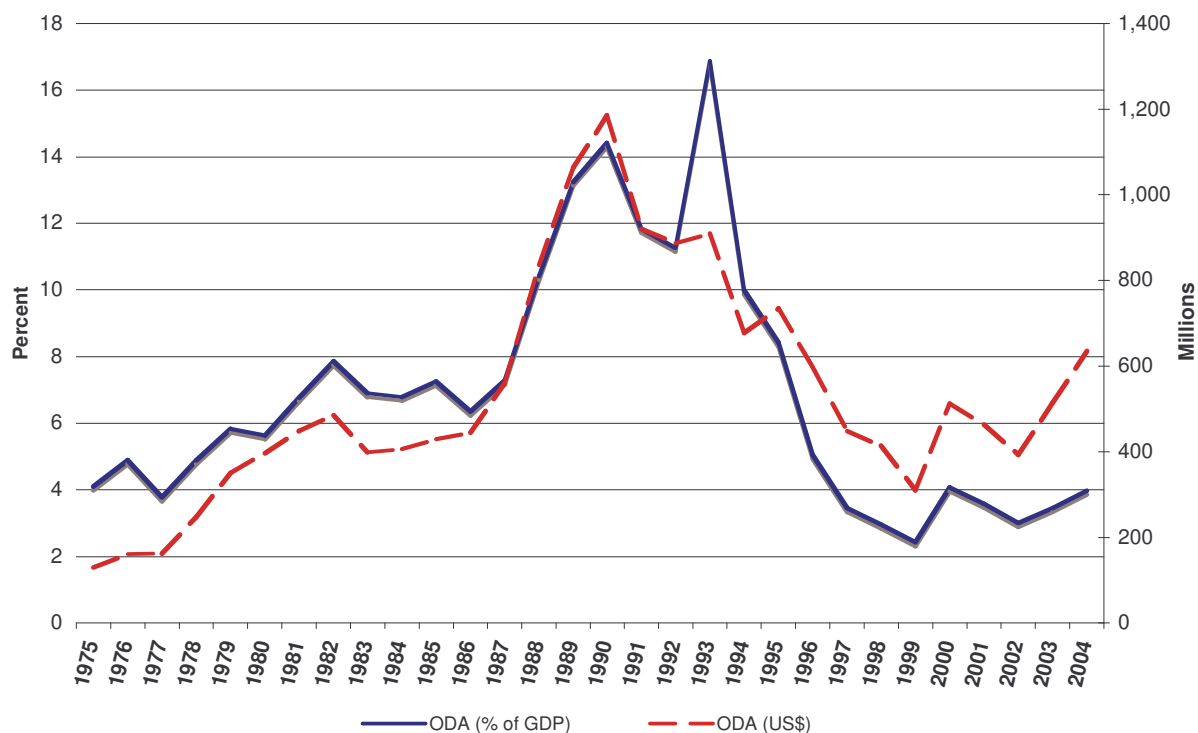
2 TRENDS IN ODA FLOWS

For the past two decades and a half, the trend in aid flows to Kenya can be categorised in three phases. The first phase, 1975-1990, was a period in which aid flows steadily increased. The second phase, 1991-1999, saw continuous decline in aid flows. The third phase, 2000-2004, was a period of slight recovery. As shown in Figure 1, aid as a share of GDP reached 17 per cent in 1993, but fell to 10 per cent in 1994 and 2.4 per cent in 1999. In monetary terms, aid flows fell from US\$ 1,185 million in 1990 to US \$310 million in 1999. By the turn of the century, aid flows bounced back to about US\$ 600 million or four per cent of GDP, reflecting the PRGF programmes agreed with the IMF in August 2000 and November 2003.

The decline in aid flows is not an accident. By the second half of the 1990s, the Kenyan Government and the multilateral lenders disagreed on the issue of conditionality. According to the Kenyan PRSP (2005, p. 23) – “The low levels of donor support were primarily driven by Kenya being ‘off track’ with key development partners and especially the Bretton Woods institutions.” Weeks et al. (2003, p. 24) also note that the fall in aid flows is related to:

“Donor dissatisfaction of government policies within Kenya, especially the issue of good governance. These figures clearly demonstrate the concerted pressure that the most important multilateral donors have brought to bear upon the Kenyan government in pushing for their own preferred programs and policies. This pattern of behaviour implies that the international institutions have imposed conditionality upon the Kenyan government in order to affect the type and speed of economic and political reforms.”

FIGURE 1
Aid in US\$ and as a Share of GDP, 1975-2004



Source: World Bank World Development Indicators (2006).

Table 1 (page 6) shows the trends in capital inflows during the 1999/2000 to 2002/03 fiscal years. For the entire period, Kenya received Ksh 52,436 million of grants and Ksh 48,480 million of loans. External finances were flowing into projects as opposed to programmes. The total inflows to the public sector budget amounted to Ksh 100,916 million. Nevertheless, the country also repaid its external principal obligations amounting to Ksh 90,059 (PRSP, 2005). This outflow of capital meant that net inflows over the period 1999/2000 to 2002/03 totaled only Ksh 10,857 million. Excluding drought-related resources, net inflows were negative.

TABLE 1
External Loans and Grants, 1999/00-2002/03, Ksh Million

	1999/2000	2000/01	2001/02	2002/03
Programme Grants	4,247	5,955	1,473	458
Project Grants (Cash)	938	1,521	1,090	3,804
Project Grants	3,309	4,160	4,260	10,777
Drought Related Grants	0	12,444	0	0
Project Loans	6,020	5,323	7,133	5,276
Programme Loans	0	4,045	0	4,045
Project Cash Loans	2,830	4,337	2,898	2,191
Drought Related Loans	0	4,382	0	0
Total Grants	8,494	24,080	6,823	15,039
Total Loans	8,850	18,087	10,031	11,512
Total External Support	17,344	42,167	16,854	26,551

Source: PRSP (2005).

3 ALLOCATION OF RESOURCES TO HIV/AIDS CONTROL

Although total ODA flows have been dwindling, Kenya has maintained its position, as shown in Table 2, as one of “the top ten main recipients of aid to health” (in US\$ million). During the period 1996-1998, Kenya received US\$61 million of aid earmarked to the health sector, making it the tenth largest recipient. Over 1998-2001, the country became the sixth largest recipient of aid flows to the health sector. Assistance was equivalent to US\$ 116 million. During the period 2002-2004, aid flows to the health sector reached US\$ 162 million, although Kenya slipped back to ninth place.

TABLE 2
Main Recipients of Aid to Health 1996-2004, Annual Average, US\$ Million

1996-1998		1998-2001		2002-2004	
India	701	India	317	India	382
Bangladesh	190	Indonesia	189	Nigeria	359
Egypt	121	Nigeria	176	China	265
Vietnam	114	Bangladesh	158	Tanzania	230
China	101	Tanzania	133	Uganda	208
Ethiopia	80	Kenya	116	Zambia	204
Tanzania	79	Mozambique	106	Mozambique	180
Indonesia	70	Uganda	104	Ethiopia	173
Uganda	63	China	84	Kenya	162
Kenya	61	Bolivia	83	Congo DR	159

Source: OECD Database.

Not only does Kenya receive a relatively significant amount of aid to the health sector, but it is also among the top ten recipients of aid earmarked to HIV/AIDS control (Table 3). Between 2000 and 2002, the country received US\$ 61 million and ranked as the second largest recipient. In per capita terms, aid to HIV/AIDS control amounted to US\$ 2, ranking Kenya fourth among the top ten countries in sub-Saharan Africa. Several donor governments provide funding, mainly the United States, the United Kingdom and Japan. Kenya is one of

the 15 focus countries of the President's Emergency Plan for AIDS Relief (PEPFAR). U.S. bilateral aid to Kenya reached US\$ 93 million in 2004 and US\$ 143 million in 2005. The Global Fund has approved three HIV/AIDS grants to Kenya in the past four years. The World Bank earmarked US\$ 100 million in funding to combat HIV/AIDS in its Multi-Country AIDS Program (MAP) for Africa, which includes Kenya. UNAIDS and other UN agencies also support a variety of HIV/AIDS activities (NACC, 2005 and UNAIDS, 2006).

TABLE 3

Top 10 Recipients of Aid to HIV/AIDS Control in Africa, 2000-2002

	Total million (US\$)	Per capita (US\$)
Nigeria	91.2	0.7
Kenya	61.3	2.0
Uganda	53.4	2.3
Zambia	43.2	4.1
Ethiopia	42.5	0.6
South Africa	35.6	0.8
Mozambique	31.3	1.7
Ghana	29.9	1.5
Tanzania	29.2	0.8
Zimbabwe	25.6	2.2

Source: OECD Database.

As shown in Table 4, aid to the health sector as a share of total expenditure on health went up from 12.8 per cent in 1998 to 15.3 per cent in 2003. Since Kenya receives significant aid for health and HIV/AIDS control, we would expect actual scaling-up of government health expenditure. However, the figures indicate that outlays in the health sector do not reflect aid flows to the sector. Public health expenditure as a share of total expenditure on health declined from 45.2 per cent in 1998 to 38.7 per cent in 2003. Public expenditure on health as a share of total government expenditure also fell, from 11.1 per cent in 2000 to 7.2 per cent in 2003. The average for low-income countries is nine per cent and the target agreed by African Heads of State is 15 per cent. Health expenditure by the public sector fell from 2.2 per cent of GDP in 1998 to 1.7 per cent in 2003 (the average for low-income countries being 2.4 per cent).

TABLE 4

Health Expenditure Indicators, 1998-2003

Year	Public expenditure on health as % of total	Aid to the health Sector as % of total expenditure on health	Public health expenditure (% of GDP)	Public as % of total government expenditure	Total health expenditure (% of GDP)	Private as % of total expenditure on health
1998	45.2	12.8	2.2	8.0	4.9	54.8
1999	41.1	13.3	1.9	4.1	4.6	58.9
2000	46.5	13.2	2.0	11.1	4.3	53.5
2001	42.8	17.2	1.8	8.0	4.2	57.2
2002	44.0	16.4	2.0	9.2	4.5	56.0
2003	38.7	15.3	1.7	7.2	4.3	61.3

Source: World Health Organisation (WHO) On-Line Database.

Table 4 (page 7) also shows that *total* health expenditure declined from 4.9 per cent of GDP to 4.3 per cent between 1998 and 2003. But private health expenditure as a share of total expenditure on health increased steadily from 54.8 per cent in 1998 to 57.2 per cent in 2001, and reached 61.3 per cent in 2003. The trend in the health sector is that donor finances are flowing directly to the private sector, NGOs and international organisations, not the Government. The data imply that when donors provide budget support earmarked to the health sector, the resources do not actually reach the line ministries, raising the problem of disbursement. As we will see later, the indications are that a significant amount of external resources have been added to reserves or used to settle government debt.

While general public expenditure in the health sector has not shown notable improvements, HIV/AIDS-related expenditure has been scaled-up considerably between 2000 and 2005, namely, by about 757 per cent. As Table 5 shows, total spending on HIV/AIDS has gone up from Ksh 2,142 million (US\$ 28 million) in 2000/2001 to Ksh 18,963 million (US\$ 240 million) in 2004/2005. By far the largest absolute increase in expenditure emanated from donors – their non-budgetary assistance went up from Ksh 1,760 million in 2000/2001 to Ksh 11,961 million in 2004/2005. For the same period, NGOs increased their expenditure five-fold, from Ksh 10 million to Ksh 24 million. Public spending on HIV/AIDS control also increased, i.e., from Ksh 70 million to Ksh 156 million.

TABLE 5

HIV/AIDS Related Expenditure by Source, in Ksh Million, 2000-2005

Year	Government	Donors budgetary	Donors non-budgetary	NGOs	Total	Total (in US\$ m)
2000/01	70	302	1,760	10	2,142	28
2001/02	10	1,165	3,539	26	4,740	60
2002/03	120	1,796	4,136	19	6,071	77
2003/04	40	2,685	5,487	22	8,234	108
2004/05	156	6,794	11,961	52	18,963	240
Total	396	12,742	26,883	129	40,150	507
% Increase over 2000/01-2004/05	122.9	2149.7	579.6	420.0	785.3	757.1

Source: KNASP (2005).

Table 6 also shows a major scaling-up of HIV/AIDS spending as a share of overall aid, i.e., from 5.5 per cent in 2000/2001 to 37.8 per cent in 2004/05, and averaging 19.4 per cent for the five years. However, as a share of GDP, this expenditure averaged a mere 0.7 per cent for the five-year period. The trend, however, is encouraging since the share of HIV/AIDS expenditure went up from 0.2 per cent of GDP in 2000/2001 to 1.5 per cent in 2004/2005. For the same period, HIV/AIDS expenditure as a share of total health expenditure expanded from 5.1 per cent to 33.8 per cent. Since health spending from public sources has not increased, public resources for HIV/AIDS control is likely to have come from reallocation of health expenditure or reduction in other health-related activities.

TABLE 6

HIV/AIDS as a Share of GDP, AID and Health Expenditure, 2000-2005

Year	HIV/AIDS as % of aid flows	HIV/AIDS expenditure as % of GDP	HIV/AIDS expenditure as % of health expenditure
2000/01	5.5	0.2	5.1
2001/02	12.9	0.5	11.0
2002/03	19.6	0.6	13.0
2003/04	21.0	0.7	16.8
2004/05	37.8	1.5	33.8
Averages	19.4	0.7	15.9

Source: Calculated from Table 4 (page 7) and World Bank *WDI*.

4 EXPENDITURE ON HIV/AIDS AND CHANGES IN THE PREVALENCE RATE

Trends in the composition of the expenditure allocations among various HIV/AIDS control methods are noted in Table 7. Spending on prevention rose from 17 per cent in 2000/2001 to 20 per cent in 2004/2005. For the same period, expenditure on care and support rose from four per cent to five per cent while expenditure on research and M&E went up from one per cent to two per cent. Expenditure on treatment and care is by far the largest component of the HIV/AIDS control strategy. On average, 57 per cent of the HIV/AIDS-related expenditure is targeted to this area. There was a six percentage point increase in expenditure related to treatment and care between 2000/2001 and 2001/2002, but this share fell to 52 per cent in 2003/2004. Expenditure on policy development was also cut from 20 per cent in 2000/2001 to 17 per cent in 2004/2005.

Recent data show that the adult prevalence rate declined to 5.9 per cent in 2005 from 6.1 per cent in 2004 and 14 per cent in 2001 (KDHS, 2003 and NACC, 2005).² The HIV/AIDS prevalence rate fell particularly among pregnant women in urban areas. Infection rates have been dropping especially in Busia, Meru, Nairobi, Nakuru and Thika, where the median prevalence rate fell from 28 per cent in 1999 to nine per cent 2003 (NACC, 2005). According to the UNAIDS/WHO (2006, p. 27) report: "this is only the second time in more than two decades that a sustained decline in national HIV infection levels has been seen in a Sub-Saharan African country." According to UNAIDS/WHO (2005): "All this is occurring against the backdrop of expanded HIV information campaigns, voluntary counseling and testing programs and gradually improving access to antiretroviral therapy" (p. 27).³

TABLE 7

Kenya Composition of Expenditure Allocations for HIV/AIDS, %, 2000-2005

Year	Prevention	Care and support	Research and M&E	Treatment and care	Policy development
2000/01	17	4	1	58	20
2001/02	18	3	1	64	14
2002/03	24	6	1	55	14
2003/04	20	5	2	52	21
2004/05	20	5	2	56	17
Averages	19.8	4.6	1.4	57	17.2

Source: UNAIDS (2006).

Researchers have highlighted that the drop in the prevalence rate is associated with behavioural changes, mainly the adoption of safer sexual behaviour. This is supported by evidence that condom use has increased from 15 per cent in 1998 to 24 per cent in 2003. In the same period, the proportion of both sexes having sexual contact with more than one partner fell by 50 per cent (Cheluget et al., 2004). As Table 8 below indicates, the Government as well as non-government actors have provided Voluntary Counselling and Testing (VCT); Prevention of Mother-To-Child Transmission (PMTCT); Anti-Retroviral Therapy (ART); and Post Exposure Prophylaxis (PEP).

By 2004, it is estimated that 300,000 individuals had used VCT facilities and the same number had accessed PMTCT prevention services (Table 8). The distribution of condoms has reached 120 million. The estimated need, however, is much higher than the services provided thus far. The KNASP target is for VCT to reach 500,000 patients by 2010, but by 2004 only 60 per cent of those who require the services had received them. While the estimated need for PMTCT is about 1.4 million, only 22 per cent of patients had received the services. The national target is to reach 713,000 patients, which is more than twice the current coverage. ART coverage is also low – only 20 per cent of those who need the therapy had accessed it.⁴ The national target is to expand the therapy to 186,000 patients.⁵ By far, most success has been registered in the distribution of condoms, where 75 per cent of the estimated need had been satisfied by 2004. A large proportion of the resources for behaviour change and prevention went to community mobilization and social marketing (NACC, 2005).

TABLE 8

Coverage of Essential HIV/AIDS-related Services

	Number provided	Estimated need	Coverage (%)	KNASP target
Voluntary Counselling and Testing (VCT)	300,000	500,000	60	500,000
Prevention of Mother-To-Child Transmission (PMTCT)	300,000	1,393,000	22	713,000
Condoms (millions)	120	160	75	160
Anti-Retroviral Therapy (ART)	50,000	248,572	20	186,000

Source: NACC (2005).

By 2004, the number of institutions providing services to control HIV/AIDS totalled 440. Of these, the government ran 246 of them or 56 per cent. Of the 383 service sites providing HIV testing, the government ran 199 or 52 per cent of them. There were also 161 sites for PMTCT program, of which 94 or 58 per cent were also managed by the public sector (Table 9). As noted above, the noteworthy feature of aid flows to Kenya is that the NGO sector accounts for a significant proportion of HIV/AIDS control expenditure. The services that have consumed most of these resources are ART and condom distribution, broadly falling under prevention, treatment and care.

TABLE 9

Number of Facilities Offering HIV/AIDS-Related Services

Managing authority	Number of facilities (weighted)	No. of service sites with HIV testing system	No. of program sites for PMTCT (weighted)
Government	246	199	94
NGOs	21	16	10
Private (for profit)	63	90	31
Faith Based Organisations	110	78	26
Total	440	383	161

Source: Calculated from NACC (2005).

Meeting KNASP targets require scaling-up HIV/AIDS spending from the 2005/06 amount of Ksh 25 billion to Ksh 45 billion by 2009/2010, or from US\$ 338 million to US\$ 605 million (Table 10). The resources made available by the Government, NGOs and donors for the year 2005/06 are estimated to be Ksh 25 billion, which means that currently there is a deficit of Ksh 1 billion. According to KNASP (2005), if resources from the Global Fund are discounted, the financing gap reaches Ksh 3 billion. The implication is that the achievement of national targets entail enhanced resource mobilisation. According to KNASP (2005, p. 38):

“A year-on-year growth of between 15% and 20% in the National Resource Envelope (NRE) is required to meet financing needs in full; this is equivalent to an additional Ksh 21 billion in 2009/10 compared with 2005/06 assuming no growth in the NRE. However, with a more realistic growth rate of 10% in NRE, the estimated gap will increase from Ksh 1 billion in the 2005/06 to Ksh 10 billion in the 2009/10.”

TABLE 10

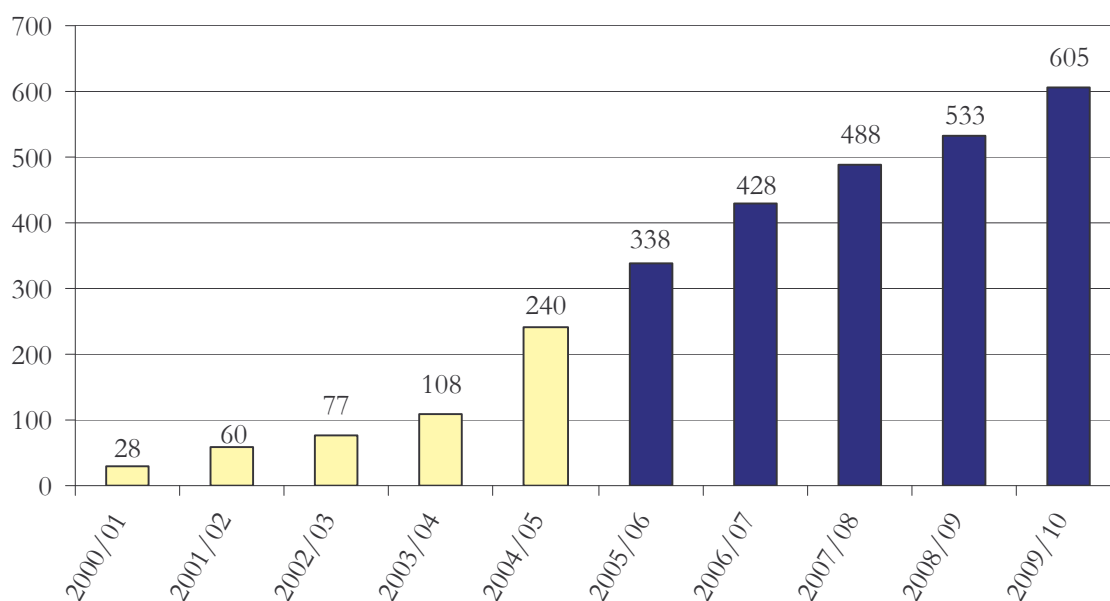
KNASP Estimated Financing Requirements, 2005/06 Prices, Ksh Millions

	2005/06	2006/07	2007/08	2008/09	2009/10	Total
Prevention	5,740	7,765	8,661	9,788	11,173	43,127
Improving the Quality of Life	7,229	8,832	10,898	12,041	13,155	52,155
Mitigation of Socio-Economic Impact	7,252	9,221	10,865	12,126	14,441	53,904
Support Services	5,110	6,303	6,202	6,024	6,627	30,266
Total (Ksh. Million)	25,331	32,121	36,626	39,979	45,396	179,452
Total (US\$ Million)	338	428	488	533	605	2,393

Source: KNASP (2005).

Figure 2 (page 12) presents a summary of past, current and estimated HIV/AIDS related expenditure. To meet the targets set in KNASP, HIV/AIDS-related spending must be scaled-up by 44.1 per cent in 2009/10 from its current level. This would be four per cent of current GDP and equivalent to 85 per cent of current health expenditure. The questions to ask at this point are: Has scaling-up HIV/AIDS spending caused macroeconomic stability? And will future expenditure to meet KNASP targets impact negatively on the macroeconomy? The next section attempts to provide answers to these questions.

FIGURE 2

HIV/AIDS-Related Expenditure, US\$ Million, 2000/01-2009/10

Source: KNASP (2005).

5 MACROECONOMIC MANAGEMENT AND SPENDING ON HIV/AIDS CONTROL

The fear expressed in some quarters is that the appreciation of currencies that would follow a scaling-up of aid would negatively affect exports. This scenario is what is commonly known as the 'Dutch Disease'.⁶ While the Dutch Disease is a theoretical possibility, there is little empirical evidence to confirm its ODA-related occurrence. In a recent paper, which studied several countries in sub-Saharan Africa, Foster and Killick (2006, p. 25) note that:

"A final positive from our findings is that the symptoms of Dutch Disease that might have been predicted from the aid surges were generally absent. An argument can be made that fears of this have been exaggerated and that non-price export constraints are a larger development problem for economies of this type, although the previous section has just cautioned against any presumption that Dutch Disease effects would be unimportant."

According to another working paper, Lewis (2005) notes a similar situation:

"HIV/AIDS related resource flows represented between 5 and 35 percent of overall aid flows to the 9 countries over 2002-2004. These limited proportions suggest that HIV/AIDS funding alone is unlikely to derail overall macroeconomic policy, although it could conceivably exacerbate macroeconomic problems associated with large aid flows" (p. 8).

Table 11 presents key macroeconomic variables and observes changes in the five years before and the five years after the scaling-up of HIV/AIDS spending in Kenya. The before period is 1995-1999 and the after period 2000-2004. The inflation rate, measured in consumer prices, averaged six per cent in the before scaling-up period compared with five per cent in the after scaling-up period. The inflation rate measured by the GDP deflator averaged 10 per cent in the before period and declined to five per cent in the after period. These findings are contrary to what one would expect from the Dutch Disease hypothesis.

Exchange rate movements also demonstrate that scaling-up spending for HIV/AIDS did not have adverse effects. In fact, the periods associated with increased aid flows and upsurges in HIV/AIDS-related spending have been associated with real exchange rate depreciation of the Kenyan shilling and high export growth rates. The real exchange rate depreciated by 3.9 per cent between the before and after periods. As illustrated in Figure 3 (page 14), the growth of exports has been striking. In the before scaling-up period, the export growth rate averaged a negative 1.5 per cent compared with a positive 8.7 per cent in the after period.

In a publication related to this topic, the IMF (2005) highlighted four scenarios of aid utilization: aid is spent and absorbed; spent but not absorbed; absorbed but not spent; and neither absorbed nor spent. Foster and Killick 2006 (p. 3) elucidates the IMF's terminology as follows:

"When aid is transferred to an economy the foreign exchange accrues in the first instance to central bank reserves, while the recipient government is credited with the value in domestic currency. We refer to the utilisation of the foreign exchange as 'absorption', and to the utilisation of the domestic counterpart as 'spending' of the aid. Aid is 'absorbed' when the balance of payments current account deficit (excluding aid) increases, either because more is imported or increased domestic demand causes producers to export less. Aid is 'spent' when the fiscal deficit (excluding aid) increases, either as a result of higher government expenditure, or lower domestic revenue."

TABLE 11

Key Macroeconomic Indicators, 1995-2004

	1995-1999	2000-2004
Deficit, Excluding grants (% of GDP)	-1.7	-0.8
Deficit, Including grants (% of GDP)	-0.9	0.4
Current Account, Excluding transfers (% of GDP)	-4.0	-5.8
Current Account, Including transfers (% of GDP)	-3.1	-4.6
Consumer Price Index	6.4	4.5
GDP Deflator	9.6	4.5
Share of ODA used for fiscal adjustments	22	33
Share of ODA used for additional imports	21	32
Reserves (US\$ million)	735	1,244
Reserves (months of imports)	2.4	3.3
Total domestic credit provided (% of GDP)	45	29
Domestic credit to private sector (% of GDP)	39	26
Interest Rate (91-Day Treasury Bills)	20.2	8.1

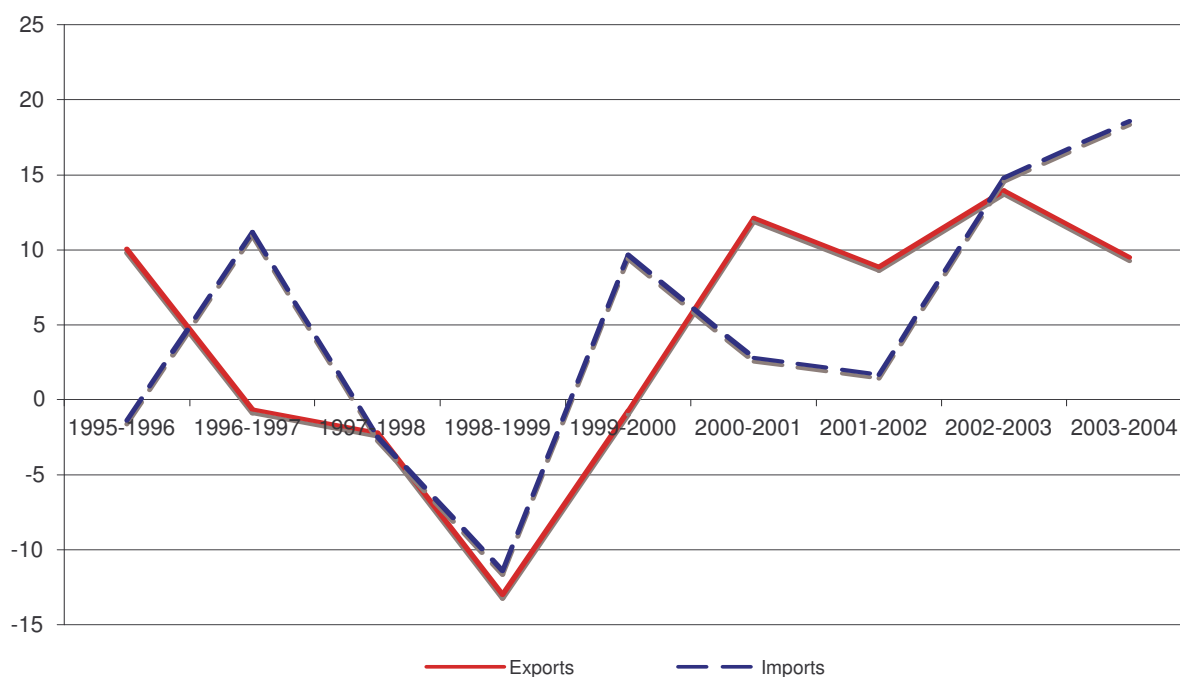
Source: Calculated from IMF's IFS and Bank of Kenya Quarterly Bulletins.

Ultimately the impact of aid surges on macroeconomic variables depends on the level of spending and absorption. Foster and Killick (2006) find that Ethiopia, Ghana, Mozambique and Sierra Leone had very low levels of foreign-exchange reserves prior to increases in aid, prompting the authorities to re-build reserves and reduce government debt rather than fully absorb increases in aid flows. The authors also find that some of the countries they studied opted to build reserves at the same time that they aimed for real depreciation of their effective exchange rates. But Mauritania, Mozambique, Tanzania and Uganda “spent all or most of the domestic counterpart to the aid increase in the form of increased public expenditure. In the case of Sierra Leone, increased aid was partly used to reduce an unsustainable level of domestic financing of the government deficit and to reduce indebtedness” (ibid. p. 17). According to Foster and Killick (2006), none of the seven case-study countries (Ethiopia, Ghana, Mauritania, Mozambique, Sierra Leone, Tanzania, Uganda) both fully absorbed and fully spent aid resources.

The record for these countries reveals great year-on-year and medium-term aid volatility, with large swings in aid receipts and past surges followed by aid declines. This has coloured the policy responses of recipient governments. The current donor promise to increase aid for the MDGs and sustain it thereafter would, if implemented, represent a sharp break from past experiences (ibid, p. v).

FIGURE 3

Growth Rates of Merchandise Exports and Imports, Value in US\$



Source: UNCTAD Database.

SPENDING

The Government of Kenya has not spent the external resource flows. This is evident from Table 11 (page 13), where the fiscal deficit excluding aid declined from -1.7 per cent to -0.8 per cent of GDP comparing the before and after scaling-up periods. Given the decline in ODA, the fiscal deficit was financed through domestic borrowing, which is estimated to be 45 per cent of total outstanding debt. About 33 per cent of the aid was, therefore, used for reducing the level of domestic financing of the government deficit and reducing existing indebtedness. As Table 12 shows, net domestic borrowing as a share of GDP declined from 5.11 per cent in 2001/2002 to 0.07 per cent in 2005/2006. Central government debt also fell from 60 per cent of GDP in 1999/2000 to 41 per cent in 2005/2006.

As indicated in Table 11, the 91-day treasury bill interest rate also fell from 20.2 per cent in the before scaling-up period to 8.1 per cent in the after period, indicating the shift in public borrowing. According to the IMF (2003), “[I]mportant objectives of the government’s economic strategy include fiscal consolidation to reduce the domestic debt to a sustainable level (p. 1).” A report by the OECD (2006, p. 8) also notes that “[T]his tightened fiscal stance in 2004/05 enabled net repayment of domestic debt to the banking sector equal to 0.3 per cent of GDP instead of a programmed domestic borrowing equal to 2.3 per cent of GDP.”

TABLE 12

Domestic and External Debt Indicators

	Net domestic borrowing (% of GDP)	Central government debt (% of GDP end of period)
1998/99	--	59.4
1999/00	--	60.2
2000/01	--	55.5
2001/02	5.11	55.4
2002/03	4.34	48.8
2003/04	1.30	45.7
2004/05	1.29	46.6
2005/06	0.07	41.4

Source: Central Bank of Kenya and Treasury, various reports.

The inflation target agreed in the PRGF programme and the PRSP for the three years of 2005, 2006 and 2007 is 3.5 per cent. According to the PRSP (2005, p. 12), “continuation of the conservative monetary policy will allow Kenya’s underlying inflation to remain below 3.5 percent, comparable with the forecasts for trading partner inflation.” On page 32, the PRSP goes on to state that the “Central Bank of Kenya continues with its monetary policy targeting a 3.5 percent underlying inflation rate”. On page 32, the same document states that the “objective of fiscal policy is to maintain revenues at above 21 percent of GDP and achieving a sustainable overall deficit (including grants) of below 3.2 percent of GDP over the 2003/2004-2006/07 period”.

Since the budget was in *surplus*, including grants, equivalent to 0.4 per cent of GDP during the scaling-up period, there is clearly some fiscal space to increase spending on HIV/AIDS without impacting on the macroeconomy. The inflation target of 3.5 per cent also seems unusually low, given the consensus, even among the multilateral agencies, that a rate between five per cent and 10 per cent need not be harmful to growth. Moreover, the evidence on the effects of inflation remains inconclusive. Some studies find no negative impact on growth of an inflation rate above 15 per cent (Temple, 2000).⁷ Thus, the macroeconomic policy stance in

Kenya appears to be unduly restrictive and leaves little room for continuing the desired scaling-up of spending on HIV/AIDS as well as the needed increases in health expenditure.

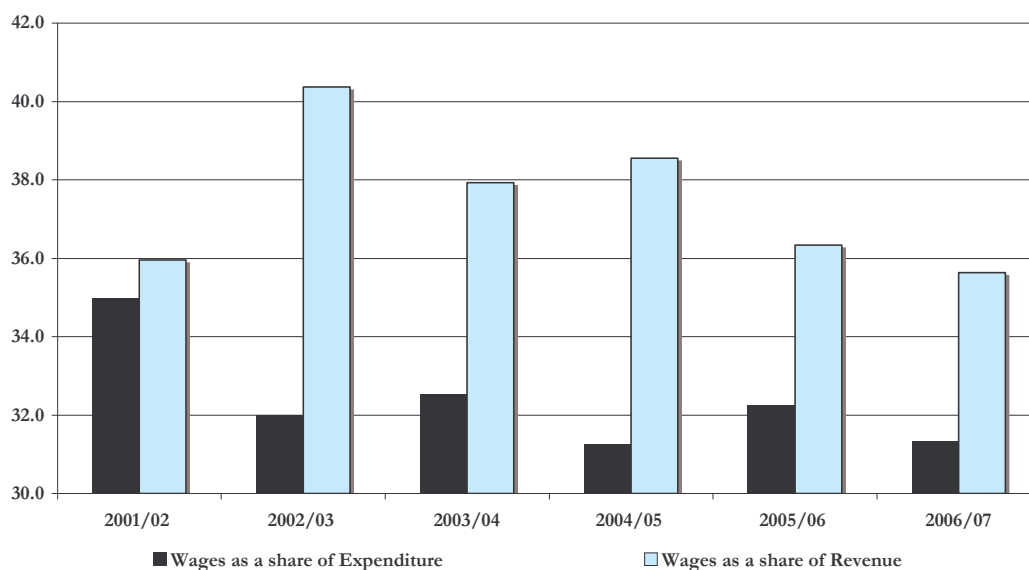
Another policy of budget deficit reduction has involved the introduction of wage ceilings. According to Fedelino et al. (2006), between 2003 and 2005 conditionalities on wage bills were imposed in 21 countries, 14 of them in sub-Saharan Africa (SSA). This included including Kenya, which had agreed PRGF programmes with the IMF. According to the same authors “as donor funding for hiring in specific sectors is set to increase, for example in the context of expanding vertical programs, the potential tensions arising from aid scaling up in the presence of wage bill ceilings may become more acute” (p. 16).

As shown in Figure 4, wages as both a share of government expenditure and a share of revenue exhibit declining trends in Kenya. The wage share in expenditure fell from 35 per cent in 2001/02 to 31 per cent in 2004/2005 and is projected to stay at this level. Wages as a share of revenue fell from 40 per cent in 2002/03 to 38 per cent in 2004/05; a further fall to 36 per cent is forecast for 2006/07. Government policy is also geared towards achieving the reduction in wages as a share of GDP from 8.7 per cent in 2003/04 to 8.5 per cent by 2005/06 and then to 7.2 per cent by 2007/08 (PRSP, 2005).

The wage ceilings coupled with reduction in public health expenditure were geared to reducing inflation to the PGRF target of 3.5 per cent. Under such tight restrictions on wage increases, it is difficult to imagine the possibility of scaling-up health spending. This austere policy stance has been felt in the health sector. Recently, the Assistant Minister for Health argued that Kenya urgently needs 10,000 new health workers. The health sector, as we saw above, has suffered from budget cuts. Not only do local clinics and hospitals lack the necessary medicine and supplies, but also key professionals have left the sector through retrenchment, retirement and for higher salaries abroad. Some estimates note that about 5,300 health staff left the sector between 2000 and 2002 (Ambrose, 2006). Recruitment was also frozen in the health sector following the public sector reform initiated five years ago. Cuts in subsidies and staff support provided to non-public facilities have also affected the growth of the non-public health sector.⁸

FIGURE 4

Wages as a Share of Expenditure and Revenue, 2001/02-2006/07



Source: World Bank *WDI*.

ABSORPTION

Aid flows in Kenya have been only partially absorbed. The current account deficit excluding grants did expand, to some extent, as a share of GDP, i.e., from -4 per cent to -5.8 per cent between the before and after periods. The growth in net imports was 1.3 per cent. The share of aid used for additional imports increased from 21 per cent to 32 per cent. This is in line with the common practice of spending HIV/AIDS-related aid on imports, particularly the import of condoms and antiretroviral drugs. According to Gupta *et al.* (2006, p. 10), for example:

“In the countries with high HIV/AIDS prevalence rates (and thus disproportionately high treatment costs), much of the external financing is likely to be spent on imports, thus mitigating the macroeconomic implications of high aid inflows. However, other components of HIV/AIDS programs, such as prevention and orphan support, largely take the form of domestic spending on nontraded goods and services.”

However, the Bank of Kenya did not sell the entire foreign exchange reserves obtained from external sources, reflected by the fact that international reserves increased from 5.6 per cent of GDP to 8.5 per cent or from US\$ 735 million to US\$ 1,244 million between the before and after scaling-up years.⁹ The bias towards accumulation of reserves is related to the requirements of the PGRF programmes, which place conditionality on saving aid resources for future periods by increasing foreign exchange reserves.

Increased reserves have also allowed policy makers to maintain the exchange rate peg against the dollar and overcome the low level of coverage in terms of months of imports, which went up from 2.4 to 3.3 months between the before and after scaling-up periods. Most of all, reserves are being designed as a buffer against capricious aid flows.¹⁰ The build-up of reserves has been accompanied, unfortunately, by a reduction in domestic credit. Between the periods 1995-1999 and 2000-2004, total domestic credit by the banking sector fell from 45 per cent of GDP to 39 per cent and credit advanced to the private sector declined from 29 per cent of GDP to 26 per cent (Table 11 – page 13).

All in all, scaling-up aid to finance HIV/AIDS spending in Kenya has had little destabilizing impact, mainly because the level of spending through fiscal expansion has not taken place. The Government of Kenya opted for the strategy of partially absorbing but not spending external resources. The Central Bank of Kenya sold some of the foreign exchange obtained through aid. But about 65 per cent of the aid in the scaling-up period was used to settle debt and increase reserves. Only the rest was used to increase net imports. This may also explain the small change in prices during the scaling-up period.

It is worth noting that the Dutch Disease has not been a problem because full expenditure on HIV/AIDS has not been made. But this does not imply that if all expenditure were made that the Dutch Disease problem would indeed arise.

There is a consensus that more aid is needed to tackle the HIV/AIDS epidemic. However, this consensus is being attacked, paradoxically, from the same groups advocating for more external resources and capital market liberalisation lest aid upsurges upset macroeconomic stability. Thus, resources are directed to reserves precisely because financial liberalisation

creates potential for greater volatility of capital flows. It is difficult to see, however, how the HIV/AIDS epidemic can be tackled in a world where financial stability takes precedence over confronting a grave human emergency.

As the case of Kenya demonstrates, key macroeconomic variables are below what could be assumed to be unstable levels. Fully spending and absorbing aid is an optimal strategy unless short-term stabilization needs are urgent. When aid is spent and absorbed, some real appreciation and moderate increases in inflation are necessary to reallocate resources, mainly through relative price adjustments. In the long-term, the Kenyan case suggests that there is room for more expansionary fiscal policies that can simultaneously address such a severe human development crisis as the HIV/AIDS epidemic and expand the economy's productive capacity through the effective utilisation of scaled-up external resources.

6 CONCLUDING REMARKS

Today we are confronted by a grave epidemic that is spreading fast and attacking the most vulnerable of the global community. The need to increase resources for tackling HIV/AIDS is not contested. What is at issue is the way that the extra resources should be spent. External aid has been the dominant source of funding for HIV/AIDS-related spending. At the same time, many economists highlight the macroeconomic challenges associated with such a scaling-up of aid. The challenges are related to whether increased external assistance inevitably causes macroeconomic instability or not.

Consistent with the literature and empirical evidence, this Conference Paper finds little evidence of the macroeconomic instability that might have been predicted from the surges in HIV/AIDS spending. Such an outcome in Kenya is explained, in part, by the cautious approach to fully spending and absorbing aid. This paper found that aid flows to Kenya have not been spent and only partially absorbed. Moreover, the resources have not been large enough to upset macroeconomic conditions.

In addition, a large proportion of HIV/AIDS spending has been allocated to importing condoms and essential drugs. Such imports imply that this proportion of ODA financing has had no monetary impact on the domestic economy. Most importantly, total ODA has been falling and public spending on HIV/AIDS has not increased the overall health budget. Hence, the fiscal implications of HIV/AIDS-related spending have been minimized.

But deep-seated fear of the macroeconomic impacts of increased aid led to a Kenyan policy stance in which absorbing and spending extra aid resources have been approached very cautiously. But the demands stemming from confronting a HIV/AIDS-related human development crisis and the cautionary prudence of financial conservatism are contradictory. Financial conservatism becomes less of a priority when policy makers are faced with major development challenges in countries where economic and social deprivations are widespread and deep. To effectively tackle the HIV/AIDS epidemic, policy makers in Kenya need to:

1. Opt for more expansionary fiscal and monetary policies: increase spending of external resources (since the fiscal deficit target under the PGRF allows a deficit of up to 3.2 per cent of GDP);
2. Reverse the decline in health expenditure, particularly in light of the linkages between HIV/AIDS and other diseases such as tuberculosis and malaria; and
3. Campaign for debt relief to Kenya that will create the additional fiscal space needed to allocate sufficient resources to combat the HIV/AIDS epidemic.

Thanks to a scaling-up of ODA for HIV/AIDS financing, Kenya has already achieved a significant reduction in the infection rate of the disease. But the country could have achieved much more if the Government had been able to maintain total health expenditures and pursue more expansionary fiscal and monetary policies to buttress an aggressive campaign against the epidemic.

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NOTES

1. Scaling-up aid for the Millennium Development Goals (MDGs), under the assumption that aid is spent on domestic goods and services, has led to fears of the Dutch Disease. However, there is no hard evidence of Dutch Disease effects following aid surges (see McKinley and Hailu, 2006; Lewis, 2005; Chowdhury and McKinley, 2006; and Foster and Killick, 2006).
2. The figure for 2005 is from the presentation made by John Kamigwi, Deputy Director of NACC, at the Global Conference on Gearing Macroeconomic Policies to Reverse the HIV/AIDS Epidemic, co-sponsored by the International Poverty Centre (IPC) and the HIV/AIDS Group of UNDP in Brasilia, 20-21 November.
3. The link between a fall in the prevalence rate and access to antiretroviral therapy is through increased awareness about the dangers of unsafe sex by the patient's partners, relatives and siblings.
4. In February 2001, the Kenyan Ministry of Health published the first edition of *Guidelines to Antiretroviral Drug Therapy in Kenya*. This was followed by the establishment of the national ARV Task Force, which is mandated to design approaches for the implementation of antiretroviral therapy projects. For instance, USAID has funded projects that have been implemented in Mombassa that have focused on expanding ARV treatment. By end 2005, access to treatment was provided to approximately 50,000 Kenyans.
5. In an influential study, Moatti *et al.* (2003, p. 247) note:

In the first two decades of the HIV epidemic, the parallel efforts of activists, scientists and clinicians resulted in a largely successful paradigm and practice for confronting the epidemic in the rich regions of the world. This was structured around prevention of HIV infection and treatment of AIDS. In resource rich countries in the north, these two key modalities have reduced the rate of growth of the epidemic as well as mortality, morbidity and health care costs. By contrast, for the vast majority (95%) of the estimated 42 million HIV-infected persons who live in developing countries, surveillance, prevention and the development of future vaccines were thought to be the only feasible modalities to combat the epidemic.

Various studies have found that ARV delivery can be successful in both middle- and low-income countries as the cases of Brazil, Cote d'Ivoire,, Senegal, Thailand and Uganda have demonstrated. Despite compelling evidence of this magnitude, scaling-up ART delivery is seen as a poor choice of investment in the developing world. The rationale behind the bias against treatment stems from the argument that resources would have a greater social benefit if invested alternatively and that institutional as well as government absorptive capacity and fiscal management problems prevent effective ART delivery management. This has resulted in a major ARV gap between the developed and developing countries. For Moatti *et al.* (2003, p. 249) "*denying expanded access to ART is not only bad ethics and bad public health, but also bad economic policy*" (emphasis as in original)
6. See McKinley (2005) and Chowdhury and McKinley (2006) for a critical treatment of the Dutch Disease.
7. In the past three decades, developing countries have witnessed positive growth and, at the same time, have become more prone to inflation (Thirlwall, 1999). Both Keynesian and monetarist views suggest that inflationary finance can mobilise resources for capital accumulation. Most studies on inflation and growth have used cross-section regression analysis similar to that of Barro (1991 and 1996). In a study of 127 countries over 1960-1992, Bruno (1995) as well as Ghosh and Phillips (1998) find positive relationships between inflation and per capita growth up to a five per cent inflation rate. Beyond this rate, per capita growth begins to slow. In a study of 87 countries over 1970 and 1990, Sarel (1996) also finds positive associations between growth and inflation up to an eight per cent inflation rate but a negative relationship beyond this rate. Barro (1996) identifies a negative impact on growth above an inflation rate of 15 per cent. But research of Bruno and Easterly (1996) sets the threshold at 40 per cent and shows that "growth falls sharply during the high-inflation crisis" and "growth after the end of the high-inflation crisis was higher than before the crisis, even though inflation had returned to about the pre-crisis level or slightly higher" (p. 213). Stiglitz (1998) also stresses that it is hyperinflation that policy makers should worry about. In fact, an inflation rate of 40 per cent can be taken as an upper threshold. There is little evidence for the Non-Accelerating Inflationary Rate of Unemployment (NAIRU), even in the developed economies (Phelps, 1993 and Bruno, 1995). The key policy lesson is to avoid persistent instability and severe deflation or hyperinflation.
8. Presentation by John Kamigwi, Deputy Director, NACC Kenya, the Global Conference on Gearing Macroeconomic Policies to Reverse the HIV/AIDS Epidemic), Brasilia, 20-21 November.
9. Other arguments also state that since aid resources are free, they can easily replace domestic revenues. So, increasing aid will be a disincentive to revenue collection efforts. Hence, this is another justification for using aid to add to reserves instead of financing additional public expenditure on domestic goods and services as well as imports.
10. There is plenty of evidence that confirms that aid volatility has high welfare costs and negative impacts on growth (Arellano *et al.*, 2005).



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